CHAPTER 2-000 REFERRAL, APPLICATION, AND ELIGIBILITY

<u>2-001 Initial Referral</u>: Individuals, parents, guardians, agencies, and physicians may refer an individual to MHCP. An application may be completed before or after the referral is received (see 467 NAC 2-002). An application may serve as a referral.

<u>2-001.01</u> Referral to MHCP: Any individual may be referred to MHCP Title V, SSI/DCP and/or Genetically Handicapped Person's Program for diagnostic, consultation services, and/or needs assessment (see 467 NAC 6-003) without -

- 1. Charge to the individual or the individual's family, except for payment by a third party which is authorized or under legal obligation to pay the charges; and
- 2. Any restriction on or requirement regarding the economic status of the individual's family or relatives.

2-001.02 Types of Referrals: A referral for services may be made by -

- Completion of the MHCP application by the applicant, the parent(s) or legal guardian, an individual acting under a duly executed power of attorney, or another person authorized to act for the applicant. <u>Note</u>: The application must list the client's diagnosis or medical problem, and at a minimum must include name of client, date of birth, phone, parents, address, and reason for referral;
- 2. A physician's referral completed by a physician provided to any office of the Department of Health and Human Services; or
- 3. Any interested person by phone, personal interview, or letter to any office of HHSS. Any written material received is considered the referral.

<u>2-001.02A Physician's Referral</u>: A physician may request both a diagnostic evaluation and/or treatment.

<u>2-001.02B</u> Referral by Interested Individual or Agency: Any parent or guardian or any other individual or agency with the consent of the parent or guardian may request an MHCP evaluation. <u>Exception</u>: MHCP provides diagnostic evaluations for eye or hearing services only when the referral is made by a medical professional or para-professional.

<u>2-001.02C Emergency Referral</u>: Physicians may refer clients to MHCP by telephone in case of emergency. MHCP Central Office staff may conditionally approve admission to an MHCP-contracted hospital pending medical and financial eligibility.

2-001.03 Receipt of Referrals

<u>2-001.03A</u> Referrals Received by the MHCP Offices: MHCP staff assign the case to a services coordinator. The services coordinator must send a letter acknowledging the referral, and initiate entries into computer.

2-001.04 Case Assignment: Families are served through the various HHS offices based on -

- 1. The client's geographical location;
- 2. The medical diagnosis;
- 3. The location of the nearest and most timely clinic that will meet the client's immediate needs; and
- 4. Client's family's or caregiver's choice when appropriate.

<u>2-001.04A</u> Children with Multiple Service Needs: For a child/client with multiple diagnoses (and multiple MHCP services), Central Office staff will assign a specific services coordinator or office to work with the family to avoid multiple services coordinators.

<u>2-001.04B</u> Referral Acknowledgment: Within ten working days after the services coordinator receives the case information, the services coordinator must notify the referral source when appropriate, and the parent or client of the receipt of the referral and the decision/action initiated by the referral. This may include-

- 1. A determination of medical eligibility;
- 2. The date of a clinic appointment or appointments with other specialists;
- 3. A request for additional information;
- 4. A request for Central Office review;
- 5. A request for medical information;
- 6. A request for completion of application; or
- 7. Referral to other programs.

The services coordinator must request the completion of release of information forms. The services coordinator must also initiate the narrative portion of the case file at this time.

<u>2-001.04B1 Completion of Release of Information</u>: When requesting completion of release of information forms, the services coordinator must allow 30 days for response. If no response is received in the first 15 days, the services coordinator must make personal contact with the client/family. If a response is not received within the 30-day period, the services coordinator must make every attempt to contact families and/or referral source before rejecting.

<u>2-001.04C Social Security Number:</u> A social security number is not required as a condition of eligibility.

In order to facilitate the application process and to coordinate benefits for other programs, the services coordinator will request the applicant's SSN. The applicant may choose to provide a SSN.

For those persons for whom a SSN is not provided, a client identification number may be obtained from the Central Office.

The services coordinator must update this information on the computer system.

<u>2-002</u> Applications: To apply for MHCP, the person who is legally responsible for the client must complete the application (attached see 467-000-13). An individual age 19 or older who is legally responsible must complete the application on his/her own behalf. Application may be made either before or after medical eligibility is determined.

Any person residing in Nebraska at the time medical services are received, or time of application, has the right to be considered for eligibility for MHCP. There is no citizenship requirement (also see 467 NAC 1-005).

<u>Exception</u>: Persons who came to Nebraska for the purpose of medical care will be rejected for eligibility based on information given.

An application may be made for an unborn child, but no case action will be taken until the child is born. If the family should request services prior to birth, medical reports specifying the need must be submitted to the Central Office for determination of coverage.

<u>2-002.01</u> Application Process: The services coordinator must conduct a face-to-face interview with the family including the client within six months after the case action date and as often as needed for services coordination but at a minimum of once each year after the first year of eligibility.

<u>2-002.01A Time Guide for Application</u>: MHCP allows the applicant 30 days from the date of the letter notifying the client of medical eligibility to make a financial application. If the client does not respond within 15 days from the date of the letter, the services coordinator must make personal contact with the client, parent(s), and/or guardian to complete the application process within a total of 45 days. If appropriate, the services coordinator may notify the referral source that the family did not apply.

Current medical and financial information must be obtained. MHCP considers any medical information less than six months old to be current.

2-002.01B Withdrawal: The applicant may voluntarily withdraw an application.

<u>2-003 Medical Eligibility</u>: Eligibility for MHCP is based on two components: medical eligibility and financial eligibility. To verify medical eligibility, the services coordinator must receive the diagnosis and the individual medical treatment plan (IMTP - also see definition at 467 NAC 1-002). The IMTP is developed by a physician or a clinic team. Based on the physician's diagnosis and the IMTP, the services coordinator must verify medical eligibility by using the chart at 467 NAC 2-003.02. Certain cases must be reviewed by the medical consultant (see 467 NAC 2-003.01B).

The medical consultant must determine medical eligibility within five working days after all necessary information is received by the medical consultant.

2-003.01 Codes: The chart at 467 NAC 2-003.02 contains the following types of codes:

- International Classification of Diseases ICD-9-CM codes (diagnosis codes);
- 2. Medical eligibility status codes; and
- 3. Service codes.

The services coordinator must enter the diagnosis and service codes into the computerized system.

<u>2-003.01A ICD Codes</u>: These are numerical codes for the client's diagnosis.

The services coordinator must use the International Classification of Diseases to obtain the diagnosis code based on the physician's diagnosis.

<u>2-003.01B Medical Eligibility Status Codes</u>: These codes indicate the client's medical eligibility status. The medical eligibility status codes are -

- 1. E: Medically eligible;
- 2. NE: Not medically eligible; and
- 3. R: To be reviewed by the medical consultant.

<u>2-003.01C Service Codes</u>: The service codes indicate the MHCP service for which each code is eligible. This information may be used to determine which services coordinator is responsible for each case; it also identifies the funding for program purposes. The code "00" indicates that the medical consultant will determine the appropriate service for each case. The service codes are -

- 00 To be assigned when medical eligibility is determined
- 02 Rheumatoid Arthritis
- 03 Scoliosis
- 04 Hemophilia
- 05 SSI/DCP
- 06 Genetically Handicapped Person's Program
- 07, 08, Reserved
- 09 Services Coordination only
- 10 Screening (for assignment or diagnostic purposes only see 467 NAC 2-001.04)
- 11 Craniofacial conditions
- 12 Cerebral Palsy
- 13 Heart
- 14 Orthopedic, General
- 15 Cystic Fibrosis
- 16 Eye
- 17 Mid-line Neurological Defects

- 18 Hearing Loss
- 19 Diabetes
- 20 Neoplasm
- 21 Major Medical, General
- 22 Reserved
- 23 Premature/High Risk Infants
- 24 Asthma
- 25 Burns
- 26 Neurological
- 27 Urological
- 28 Reserved
- 29 Services Coordination

<u>2-003.02 Medical Eligibility Chart</u>: The services coordinator must use the following chart to verify medical eligibility.

ICD Codes	Medical Eligibility Status	Service Code
000 - 010.9	NE	
011 - 013.9	R	00
014 - 014.8	NE	
015 - 015.9	E	14
016 - 018.9	R	00
020 - 041.9	NE	
045 - 045.1	E	14
045.2 - 045.9	NE	
046 - 047.9	NE	
048 - 049.9	R	00
050 - 061	NE	
062 - 064	R	00
065 - 092.9	NE	
093 - 094.9	R	00
095 - 129	NE	

130 - 130.9 R 00 131 - 136.9 NE 137 - 137.4 R 14 138 E 14 139.0 R 14 139.1 R 14 139.8 R 20 210 - 239 E 20 240 NE 21 241 R 21 242 - 244 E 21 245 - 246 R 21 250 E 19 251 R 00 252 - 253 E 21 254 - 259 R 21 260 - 268 R 00	ICD Codes	Medical Eligibility Status	Service Code
131 - 136.9 NE 137 - 137.4 R 14 138 E 14 139.0 R 14 139.1 R 14 139.8 R 20 210 - 239 E 20 240 NE 20 241 R 21 242 - 244 E 21 245 - 246 R 21 250 E 19 251 R 00 252 - 253 E 21 254 - 259 R 21	130 - 130.9	R	00
137 - 137.4 R 14 138 E 14 139.0 R 14 139.1 R 14 139.8 R 20 240 - 239 E 20 240 NE NE 21 241 R 21 242 - 244 E 21 245 - 246 R 21 250 E 19 251 R 00 00 00 00 00 252 - 253 E 21 00			
138 E 14 139.0 R 14 139.1 R 139.8 140 - 209 E 20 210 - 239 R 20 240 NE 21 241 R 21 242 - 244 E 21 245 - 246 R 21 250 E 19 251 R 00 252 - 253 E 21 254 - 259 R 21			14
139.0 R 14 139.1 R 139.8 R 140 - 209 E 20 210 - 239 R 20 240 NE 241 R 21 242 - 244 E 21 245 - 246 R 21 250 E 19 251 R 00 252 - 253 E 21 254 - 259 R 21			14
139.8 R 140 - 209 E 20 210 - 239 R 20 240 NE 241 R 21 242 - 244 E 21 245 - 246 R 21 250 E 19 251 R 00 252 - 253 E 21 254 - 259 R 21	139.0	R	14
140 - 209 E 20 210 - 239 R 20 240 NE 241 R 21 242 - 244 E 21 245 - 246 R 21 250 E 19 251 R 00 252 - 253 E 21 254 - 259 R 21	139.1	R	
210 - 239 R 20 240 NE 241 R 21 242 - 244 E 21 245 - 246 R 21 250 E 19 251 R 00 252 - 253 E 21 254 - 259 R 21	139.8	R	
240 NE 241 R 21 242 - 244 E 21 245 - 246 R 21 250 E 19 251 R 00 252 - 253 E 21 254 - 259 R 21	140 - 209	E	20
241 R 21 242 - 244 E 21 245 - 246 R 21 250 E 19 251 R 00 252 - 253 E 21 254 - 259 R 21	210 - 239	R	20
242 - 244 E 21 245 - 246 R 21 250 E 19 251 R 00 252 - 253 E 21 254 - 259 R 21	240	NE	
245 - 246 R 21 250 E 19 251 R 00 252 - 253 E 21 254 - 259 R 21	241	R	21
250 E 19 251 R 00 252 - 253 E 21 254 - 259 R 21	242 - 244	E	
251 R 00 252 - 253 E 21 254 - 259 R 21	245 - 246		
252 - 253 E 21 254 - 259 R 21			
254 - 259 R 21			
260 - 268 R 00			
268.0 - 268.1 E 14			
268.2 - 269 R 00			
270 - 273 R 21			
274 R 00			
275 - 276 R 21			
277.0 R 15 (Adults-06)			
277.1 - 277.9 R 21			21
278 NE			0.4
279 R 21			21
280 - 281 NE			04 (4 dulta 00)
282 - 283 R 21 (Adults - 06)			,
284 E 21			
285 R 21 286.0 - 286.1 E 04 (Adults - 06)			
,			,
287 R 21 288 – 289.9 R 21			
290 – 307.22 NE			21
307.23 R 21			21
307.3 – 326 NE 00			
330 - 331.1 R 00			
331.2 R			UU
331.3 - 331.4 R 00			00
331.7 - 331.9 NE			

ICD Codes	Medical Eligibility Status	Service Code
332.0	R	00
332.1	NE	
333 - 333.0	R	00
333.1	NE	
333.2 - 333.3	R	00
333.4	E	21
333.5 - 333.99	R	00
334 - 336.0	R	00
336.1 - 337.9	R	00
340 - 342	E	26
343 - 344	E E	12
345	NE	26
346 347 - 349.9	NE R	00
350 - 359.9	R R	00
360.0 - 362.43	R	16
362.5 - 362.6	NE	10
362.7	R	00
362.8 - 363.2	R	16
363.3 - 363.4	NE	10
363.5 - 363.9	R	16
364.0	NE	. 0
364.1 - 365.9	R	16
366.0	Е	16
366.1	NE	
366.2 - 366.9	R	16
367	NE	
368.0 - 368.3	R	16
368.1 – 371.9	NE	
371 – 371.9	R	
372.0 - 372.39	NE	
372.4	R	00
372.5 - 377.2	NE	
377.3 - 377.6	R	00
377.7 - 377.9	NE	40
378.0 - 378.7	E	16
378.8 - 378.9 379.0 - 379.2	R	00
379.3 - 379.4	NE R	00
379.5 379.5	R R	16
379.8 - 379.9	R R	00
380 - 382.0	NE	00
382.1 - 382.9	R	18
383.0	NE	10
383.1 - 385.9	R	18
386	NE	
	· ·=	

ICD-9 Codes	Medical Eligibility Status	Service Code
387	R	18
388.0 - 388.1	NE	
388.2	R	18
388.3	NE	
388.4 - 388.5	R	18
388.6 - 388.9 389	NE R	18
390 - 397	E	13
398	R	13
401 - 405.9	R	00
410 - 417.9	Ë	13
420	NE	
421 - 427.69	R	13
427.8 - 427.89	R	13 and/or 29
427.9 - 429	R	13
430 - 438	R	00
440 - 442	E	13
443 - 448	R	00
451	NE D	00
452 - 453 454 - 455	R NE	00
454 - 455 456 - 459	R	00
460 - 466	NE	00
470 - 471.9	R	00
472 - 492	NE	
493 - 494	R	24
495 - 511	R	00
512 - 513	R	00
514 - 518	NE	
519	R	
*520 - 525	E	
526 – 530.84	R	
531 – 551	NE D	04
551.2 551.3	R R	21 21
551.4 - 553.2	R R	21
553.3	R	21
553.8 - 553.9	R	21
555 - 555.9	R	19
556	R	19 or 21
557 - 558.2	NE	
558.9	R	19
560 - 570	NE	
571	E	21
572 - 573	R	00
574 - 576	NE	

^{*}Only clients certified for service codes 11 and 12 are eligible for dental treatment under these codes.

ICD-9 Codes Me	edical Eligibility Status	Service Code
577	R	00
578 - 579.1	NE	
579.2	R	19
579.3 - 579.9	R	00
580	NE	
581 - 582	R	27
583 - 584	R	27
585 - 590	R	07
591 - 592	E	27
593	R E	27 27
594 595	NE	21
595 596	R	27
597	NE	21
598	E	27
599	R	27
600 - 618	NE	21
619	R	
620 – 709	NE	
710 - 711	R	14
712	R	02
713.0 - 713.1	R	
**713.2 (282.4-282.7)	R	21
(286.0-286.2)	R	04 (Adults 06)
(204.0-208.9, 202.	3) R	20 `
(203.0)	R	21
713.3 - 713.4	R	
***713.5	R	00
(094.0, 250.6, &		
336.0)	R	00
713.6 - 713.7	R	
714.0 - 714.4	E	02
714.8 - 714.9	R	02
715	E	14
716.0 - 716.2	R	14
716.3 - 716.4	NE	4.4
716.5 - 717.6	R	14
717.7	NE	4.4
717.8 - 718.1	R	14
718.2 - 718.8	R	14
718.9	R NE	14
719.0 - 719.1 719.2 - 719.3	R	14
719.2 - 719.3 719.4	NE	14
1 13. 4	INL	

^{**}Do not assign 713.2. Use the codes listed in parentheses as appropriate.

^{***}This is a general condition. Use the codes listed in parentheses if appropriate.

ICD-9 Codes	Medical Eligibility Status	Service Code
719.5	R	14
719.6	NE	
719.7 - 719.9	R	00
720.0	E	02
720.1 - 721.5	R	14
721.6	R	00
721.7 - 726.0	R	00
726.1 - 726.11	R	14
726.12 - 727.09	R	14
727.1	R	14
727.2 - 727.3	R	14
727.4	R	
727.5 - 727.6	R	14
727.8	R	14
727.9	R	14
728.0	R	
728.10 - 728.11	R	14
728.12 - 728.19	R	14
728.2	R	
728.3	E	14
728.4 - 728.5	NE	
728.6 - 728.7	E	14
728.8 - 729.6	R	14
729.8 - 729.9	NE	
730 - 733	Е	14
734 - 735	R	14
736 - 736.9	R	14
737 - 737.9	R	33
738 - 739.9	R	14
740	R	26
741 - 741.9	E	17
742	R	26
742.1 - 742.2	R	17
742.3	E	17
742.4 - 742.9	R	17
743.0 - 743.3	R	16
743.4 - 743.9	R	16
744.0 - 744.1	R	18
744.2	R	11
744.3 - 744.4	R	00
744.5	R	14
744.8 - 744.9	R	11
745.0 - 747.49	E	13
747.5 - 747.6	NE	
747.8 - 747.9	R	13
748.0 - 748.1	E	11

ICD-9 Codes	Medical Eligibility Status	Service Code
748.2 748.3 - 748.9 749.0 -749.25 750.0 - 750.2 750.3 750.4 750.5 750.6 - 750.9	E R E R R R	21 21 11 11 21 21 21 21
751.0 751.1 751.2 - 751.3 751.4 - 751.9 752.0 - 752.4	R R E R R	00, 21 21 21 21
752.5 - 753.1 753.2 753.3 - 753.4 753.5 753.6 - 753.9 754 - 755.1	R E R E R R	27 27 27 27 27 27 00
755.2 - 755.60 755.61 - 755.69 755.8 - 755.9 756.0 - 756.10 756.11 - 756.19	R R R R	14 14 14 00 00
756.2 - 756.3 756.4 756.50 - 756.51 756.52 - 756.59 756.6 - 756.7 756.8 - 757	R R E R E R	14 14 14 14 21 14
757.0 757.1 757.2 757.3 757.4 - 757.9	E R NE R R	14 14 21
758.0 - 758.3 758.4 758.5 - 758.9 759.0 - 759.1 759.2 - 759.3	R NE R NE R	21 21 21
759.4 - 759.5 759.6 - 759.9 760 - 764.9 765.0 – 766.2 767.0 767.1 - 767.3	E R NE R R R	21 00 23 21, 23

ICD-9 Codes	Medical Eligibility Status	Service Code
767.4	R	00
767.5	R	
767.6 - 767.9	R	00
768.0 - 768.9	NE	
769	R	23
770.0 - 770.1	NE	
770.2 - 770.3	R	21, 23
770.4	R	00
770.5	R	21, 23
770.6	NE	
770.7	R	23
770.8 - 770.9	R	23
771	R	
772.0	NE	
772.1 - 772.2	R	21, 23
772.3 - 773.3	NE	
773.4	R	21, 23
773.5 - 774.6	NE	
774.7	R	21, 23
775 - 777.4	NE	
777.5 - 777.6	R	21, 23
777.8 - 777.9	NE	
778.0	R	21, 23
778.1 - 778.9	NE	
779.0	R	00
779.1 - 779.9	NE	

<u>2-003.02A Medical Eligibility Response Codes</u>: When the medical consultant reviews cases for medical eligibility, s/he must assign one of the following codes to each case to indicate the medical eligibility decision:

- R₂: Medically eligible;
- 2. R₃: Not medically eligible (The client would be medically eligible if the problem were more severe);
- 3. R_{Δ} : No service available to cover this problem;
- R₅: Not eligible, no active medical treatment plan (The client would be medically eligible if an active medical treatment was indicated or recommended);
- 5. R₆: Continued referral (Sufficient medical information is not available to make a decision on medical eligibility. The services coordinator must request new medical information as it becomes available); and.
- 6. R₇: Services Coordination only.

<u>2-003.02B Continued Referrals</u>: In evaluating the medical needs of a client referred to MHCP, the medical consultant may request more definitive diagnostic studies or a repeat evaluation at a later date before making a decision on medical eligibility. The medical consultant must code these cases as "R₆". These requests are continued referral.

Services coordination can be provided until determined medically eligible. MHCP does not cover recommended care during this period except for specific diagnostic studies which are authorized for payment by the medical consultant. The services coordinator must notify the client or the client's family of the continued referral by letter.

The services coordinator must assist families with their questions and concerns regarding the child's/family's needs, by referring to appropriate programs and services, until determined medically eligible.

<u>2-003.03 Medical Eligibility Redetermination</u>: For all services which do not conduct clinics, the services coordinator must submit the medical file, including a current progress report (i.e., a report completed within the previous six months) to the medical consultant for review. The services coordinator must attach a note to the case when submitting a case for review only. At the time of the financial review the services coordinator must determine the schedule for these medical reviews as follows:

- 1. Compare the date of the financial review to the date of the most recent review by the medical consultant; and
- 2. If 12 months or more have passed, a review is due; or
- 3. If 11 months or fewer have passed, no review is due.

<u>Note</u>: Medical reviews by clinic teams may take the place of medical consultant reviews for those services.

<u>2-004 Financial Eligibility</u>: Financial eligibility for MHCP Title V services and for the Genetically Handicapped Person's Program is based on -

- 1. The probable cost of specialized medical care; and
- Income and resources available to the parents or client to pay for the specialized medical care.

<u>2-004.01</u> Eligibility for Other Programs: An individual who is eligible for Social Services Block Grant, TANF, AABD, Food Stamps, any Medicaid (Title XIX or XXI of the Social Security Act) without a spenddown (see 467 NAC 2-004.01B), State Disability Program, Low Income Energy Assistance Program, Child Care Subsidy, or Refugee Resettlement Program is automatically financially eligible for MHCP.

The services coordinator must consult with Central Office staff regarding eligibility for children who are covered under the subsidized adoption program.

<u>2-004.01A Eligibility Verification</u>: The services coordinator taking the application must verify eligibility for Department-administered programs by collateral contacts within the Department, by viewing the client's Nebraska Medicaid Card (eligibility card), or by viewing or printing a Departmental computer screen that shows current Medicaid eligibility or eligibility for another Departmental program (see 467 NAC 2-004.01). The services coordinator must note the contact in the narrative case record.

<u>2-004.01B MA With Excess</u>: If an MHCP-eligible client is also eligible for medical assistance (MA) with excess, the services coordinator must consider the MHCP-eligible client ineligible for Medicaid when authorizing services. <u>Note</u>: Any MHCP payment must be counted toward the spenddown. Once the spenddown is met, the services coordinator must consider the MHCP-eligible client as Medicaid-eligible when authorizing MHCP services.

<u>2-004.01C</u> Application for Other Programs: During the application process, the services coordinator must refer the client to other programs for which the client may be eligible. The client, parent(s), or guardian must apply for medical services available through other programs, including Medicaid, which access federal funds. If not eligible, the client, parents, or guardian must provide a copy of the notice of denial to the services coordinator. The services coordinator may substitute his/her knowledge of other programs for a notice of denial when it appears the client is not eligible for other programs; this must be documented in the case file. The services coordinator may document verbal inter-agency communication in the narrative. Failure to apply for other programs during the application process is grounds for rejecting or closing the case.

<u>2-004.02 Family</u>: Family means a unit consisting of one or more adults (individuals 19 or older) and children, if any, related by blood, marriage, or adoption who reside in the same household. An unborn child may be included if proof of pregnancy is obtained. The following are considered separate families:

- 1. Related adults other than spouses and unrelated adults who reside together;
- 2. Children living with non-legally responsible relatives; and
- 3. Emancipated minors.

An individual age 19 or older living at home is considered a separate family unit. The services coordinator must consider only the individual's income and resources. Family support is considered contributions.

<u>2-004.03</u> Financial Eligibility Determination: To determine financial eligibility, the services coordinator must consider countable income and resources, minus deductions, in comparison to MHCP's financial criteria. If the client exceeds the criteria, s/he may be eligible "with a financial margin." The financial margin is 25 percent of the amount by which the client exceeds MHCP's financial-criteria, minus allowable deductions from that amount (see 467 NAC 2-004.06). The client must spend or obligate the financial margin for medical care for the client before MHCP begins to pay for services.

The services coordinator must determine financial eligibility using financial information from appropriate forms and income tax forms for the self-employed person. The amounts used to determine financial eligibility are those declared on the application or income tax forms. The services coordinator must contact MHCP Central Office staff in cases where tax forms are not available for self-employed.

<u>2-004.03A</u> Sources of Income: When determining eligibility, the services coordinator must consider the following sources of income:

<u>2-004.03A1 Irregular Income</u>: Irregular income is income, earned or unearned, which varies in amount from month to month or which is received at irregular intervals. This may be due to irregular employment, but even when an individual works regularly, the income may be irregular because of factors such as seasonal increases or decreases in employment and earnings. The following are types of irregular income:

- 1. Day labor; and
- 2. Sales work on commission basis.

The services coordinator must use an average of amounts received during the last year, if available, to project future income unless there has been a significant change. Note: The average amount calculated by the services coordinator applies to the entire year, unless there is a significant change in irregular income.

Small, irregular earnings which are not computable or predictable are not considered.

<u>2-004.03A2 In-Kind Income</u>: In-kind income is any non-monetary consideration received by a client in place of income for services provided or as payment of an obligation, such as rent-free housing or farming or as a minister.

<u>2-004.03A3 Lump Sum Income</u>: Lump sum income is money received on a one-time basis. The services coordinator must add the amount of the lump sum to the yearly income to determine financial eligibility. Lump sum income includes:

- 1. Estates;
- 2. Retirement pensions which are not re-invested in other retirement accounts;

- 3. Inheritances or payments received from insurance; and
- 4. Child support or Social Security (contact Central Office for assistance in considering unusual lump sum payments).

<u>2-004.03A4 Earned Income</u>: Earned income is money received from wages, tips, salary, commissions, self-employment, or items of need received in lieu of wages. Earned income includes:

- Gross wages/salary total money earnings received for work as an employee, including wages, salary, armed forces pay, earnings through the Job Support Program, work-study, vocational rehabilitation incentive pay, commissions, tips, piece rate payments, and cash bonuses earned before deductions are made for taxes, bonds, pensions, union dues, and similar purposes.
- 2. Military allotments (i.e., additional income for spouse, dependants, etc.)
- 3. *Net income from farm self-employment gross income minus operating expenses from the operation of a farm received by a client or parent(s) as an owner, renter, or sharecropper. Gross income includes the value of all products sold, government payments, money received from the rental of farm equipment to others, and incidental receipts from the sale of wood, sand, gravel, and similar items. Operating expenses include cost of feed, fertilizer, seed, and other farming supplies, cash wages paid to farmhands, depreciation and interest, cash rent, farm building repairs, property taxes (not state and federal income taxes), and similar expenses. The value of fuel, food or other farm products used for family living is not included as part of net income.
- 4. *Net income from non-farm self-employment gross income minus expenses from one's own business, professional enterprise, or partnership. Gross income includes the value of all goods sold and services rendered. Expenses include costs of goods purchased, rent, heat, light, power, depreciation and interest charges, wages and salaries paid, property taxes (not personal income taxes), and similar costs. The value of salable merchandise consumed by the proprietors of retail stores is not included as part of net income.

Individuals with self-employment income must submit a complete copy of the previous year's federal income tax return including all schedules any time they complete the application or when requested.

<u>2-004.03A5</u> Unearned Income: Unearned income includes but is not limited to

Supplemental Security Income (SSI);

- Social Security Social Security pensions, survivor's benefits, and permanent disability insurance payments made by the Social Security Administration and Railroad Retirement payments prior to deductions for medical insurance;
- 3. Dividends includes dividends from stockholdings or membership in associations:
- 4. Interest on savings or bonds, averaged over the period earned;
- 5. *Rentals net income from rental of house, store, or other property;
- Net land lease income;
- 7. Boarders gross payments from boarders or lodgers (if self-employed, see item 4 under 467 NAC 2-004.03A4);
- 8. Royalties net royalties;
- Retirement pensions retirement or pension benefits paid to a retired person or his/her survivors by a former employer or by a union, either directly or through an insurance company;
- 10. Veteran's pensions money paid by the Veteran's Administration to disabled members of the armed forces or to survivors of deceased veterans, subsistence allowances paid to veterans for education and on-the-job training, and "refunds" paid to ex-servicemen as G.I. insurance premiums;
- 11. Contributions (i.e., family support);
- 12. Unemployment compensation compensation received from government insurance agencies or private companies during periods of unemployment and any strike benefits received from union funds:
- 13. Services coordinator's compensation compensation received from private or public insurance companies for injuries incurred at work;
- 14. Court-ordered alimony and child support (i.e., cash or direct or indirect payments made to the family);
- 15. All money contributed for the maintenance of a state or county ward, including foster care payments.

*Note: When calculating net income, if the dollar amount is negative, the services coordinator must count net income as zero.

<u>2-004.03B</u> Income Exclusions: When determining eligibility, the services coordinator must not consider the following sources of income:

- 1. Money received from participation in the Foster Grandparent Program authorized by the ACTION Program:
- 2. Money awarded by the Indian Claims Commission or the Court of Claims;
- 3. Alaska Native Claims Settlement Act payments (to the extent that these payments are exempt from taxation under section 21(a) of the Act);
- 4. Withdrawals of bank deposits:
- 5. Money borrowed;
- 6. Tax refunds;
- 7. Cash gifts under \$500;

- 8. The value of the coupon allotment under the Food Stamp Act of 1964, as amended:
- 9. The value of USDA donated foods:
- 10. The value of supplemental food assistance under the Child Nutrition Act of 1966 and the special food service program for children under the National School Lunch Act, as amended:
- 11. Any payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
- 12. Earnings of all children (age 18 and younger);
- 13. Loans and grants (such as scholarships) obtained and used under conditions that prohibit their use for current living costs;
- 14. Home produce used for household consumption;
- 15. Reimbursement from the Senior Companion Program; and
- 16. Low Income Energy Assistance funds.

<u>2-004.03C</u>: To determine one month's income, the services coordinator must use gross wages for a wage-earner. For a self-employed person, the services coordinator must divide net income from self-employment as entered on the income tax forms by 12.

<u>2-004.03D</u> Self-Employment Income: Individuals with self-employment income must submit a complete copy of the previous year's federal income tax return including all schedules anytime they complete the application or when requested.

<u>2-004.04</u> <u>Deductions</u>: The services coordinator must deduct the following from countable income:

- 1. Child support paid;
- 2. Alimony paid:
- 3. Child care necessary for employment or education if both parents are employed or receiving education or if one parent is unavailable for child care due to absence or incapacity. Education is defined as enrollment in, and regular attendance at, vocational or educational training to attain a high school or equivalent diploma or an undergraduate degree or certificate designed to fit him/her for paid employment. This excludes students pursuing second undergraduate degrees, second certificates, or any post-graduate schooling;
- Tuition and books for family members attending school (excluding private elementary and secondary schools and students pursuing second undergraduate degrees, second certificates, or any post-graduate schooling);
- 5. Medical expenses for the entire family, including medical insurance premiums, paid within the 12 months preceding the date of application.

<u>2-004.04A Medical Expenses</u>: Expenses allowed for the previous year's financial margin are not counted for the current year's medical expenses (see 467 NAC 2-004.06). The services coordinator must subtract the expenses allowed as declared on the previous year's application forms.

<u>2-004.05</u> Financial Guidelines: The services coordinator must compare the family's countable income minus any deductions, to MHCP's financial criteria:

Financial eligibility through MHCP is available to children with special health care needs who medically qualify if the family income is at or below 185 percent of the federal poverty level for the appropriate family size.

<u>2-004.06 Financial Margin</u>: If the family's income minus deductions exceed MHCP's financial criteria, the services coordinator must calculate the client's financial margin. The financial margin is 25 percent of the amount which exceeds the guidelines.

<u>2-004.06A</u> Financial Margin Deductions: The services coordinator must deduct the following from the financial margin:

- Unpaid medical bills for the client not included in the previous year's medical allowance. <u>Note</u>: Paid medical bills are considered under 467 NAC 2-004.04, item 5:
- 2. Projected travel and lodging costs at state employee rates for specialized medical care:
- 3. Actual funeral expenses of the client; and
- 4. Projected cost of child care for siblings while the client is hospitalized or receiving medical services.

If the services coordinator finds other disability-related expenses not listed, s/he must consult the Central Office.

The services coordinator must compare the amount remaining after all applicable deductions are subtracted from the margin to the projected cost of medical care for the client for the next year. The services coordinator may consult MHCP Central Office staff to determine the projected cost of care. The services coordinator must consider how much of the margin will be paid for by any third party. If the amount remaining is more than the projected cost of care, the applicant is ineligible.

If the projected cost of care is more than the remaining amount, the family must spend or obligate the remaining amount of the financial margin for medical care for the client before MHCP begins to pay.

The services coordinator must determine the client financially ineligible if it appears that the margin will not be met. The services coordinator must reject or close the case as appropriate on the computerized system.

<u>2-004.07</u> Redetermination of Eligibility: Redetermination of financial eligibility is required every 12 months beginning one year from the case action date. For each annual review, the services coordinator must notify the client, parent(s), or legal guardian by letter that the redetermination of eligibility is due in 30 days. If no response is received within 30 days, the services coordinator must send a second notice, allowing an additional 30 days. If no response is received within the second 30-day period, the services coordinator must make every attempt at a personal contact to advise the client, parent(s) or legal guardian of closing the case, then close the case, effective up to 30 days after the last review was due.

The services coordinator must complete necessary redetermination forms and enter appropriate information into the computerized system.

The services coordinator must complete a redetermination of eligibility when information is obtained about changes in a client's circumstances that may change his/her eligibility. The services coordinator must complete this review as soon as possible within 30 days after receiving the information.

2-004.07A Eligibility Redetermination When Other HHSS Program Eligibility is Verified: When the client's eligibility for another HHS program is verified by collateral contacts within the Department, by viewing or printing a HHS computer screen that shows current Medicaid eligibility or eligibility for another HHS program (see 467 NAC 2-004.01), the family need not complete another application. The services coordinator must note the methods of verification in the narrative case record. This action and procedure serves as the MHCP eligibility redetermination for clients who are eligible for other HHS programs.

2-005 Case Action

<u>2-005.01 Certification</u>: The services coordinator must determine eligibility within 10 working days after all financial and medical eligibility information is received. The services coordinator must certify an applicant who has been determined medically and financially eligible for a plan of medical care on the computerized system. The services coordinator must notify the parents, client, or guardian of certification for MHCP services by letter. The services coordinator must notify appropriate MHCP-contracted providers of certification and authorization to provide specified care.

<u>2-005.01A Certification Date</u>: The certification date is the effective date of eligibility. See 467 NAC 4-000 ff. for specifics for each service.

<u>2-005.02</u> <u>Denials</u>: The services coordinator must deny applications or referrals for individuals determined ineligible for MHCP, based on the following reasons:

- 1. Diagnosis which is not covered by MHCP;
- 2. No active treatment;
- Insufficient medical need:
- 4. Financial ineligibility;
- 5. The family's or guardian's decision to provide care privately;
- 6. Lack of cooperation;
- 7. Failure to apply after the client was referred for services (see 467 NAC 2-002.01C);
- 8. The client is over age 21;
- 9. Failure to complete the application; or
- 10. Care covered by other programs.

Within five working days after the rejection decision, the services coordinator must notify the client, refer him/her to other appropriate programs, and record the rejection on the computerized system.

2-005.03 Closings: The services coordinator must close an MHCP case when -

- 1. The client has received maximum benefit as determined by the medical consultant;
- 2. The parents, client, or guardian desire private care;
- 3. The parent, guardian, or client is not interested in further services:
- 4. The client reaches age 21 (<u>Exception</u>: See the Genetically Handicapped Person's Program at 467 NAC 6-000 ff.);
- 5. The client dies:
- 6. The client moves from Nebraska:
- 7. The client becomes financially ineligible;
- 8. The client fails to complete the yearly redetermination of eligibility (see 467 NAC 2-004.07):
- 9. The service has been discontinued:
- 10. The client fails to cooperate with MHCP regulations and policies;
- 11. The client is institutionalized; or
- 12. The client's needs are covered by other programs.

The services coordinator must close the case on the computerized system. The services coordinator must provide written notice to the parent, guardian, or child at least ten days before the effective date of closing. This notice must include information about -

- 1. The effective date;
- 2. The right to appeal; and
- 3. Reasons for closing and citation of manual reference.

2-006 Transfer of Cases

<u>2-006.01</u> From One MHCP Services Coordinator to Another: When a case is transferred from one MHCP services coordinator to another, the MHCP services coordinator must send all case files to the new MHCP services coordinator (wherever located) and enter the transfer information into the computerized system.

<u>Note</u>: If the child resides in a different service area than the parent(s) or guardian, the case remains the responsibility of the office in the service area where the parent(s) or guardian reside.

<u>2-006.02 To Another State</u>: When a client moves to another state, the services coordinator must attempt to obtain the new address and contact the Central Office staff for information for the Children with Special Health Care Needs Program in that state. MHCP Service Coordinators must arrange the transfer of the case to the agency which provides Title V services in the new state of residence.

<u>2-006.03</u> From Another State To Nebraska: When MHCP staff learn of a client who has moved to Nebraska and has been receiving Title V services elsewhere, they must notify the appropriate services coordinator and send any information received to the services coordinator. The services coordinator must contact the client's family and inform them of services available in Nebraska. An application is required if the client wishes to receive services in Nebraska. Information sent by the Title V office in the former state of residence may be used as a referral.

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<u>2-007 Record Retention</u>: Four years after the date the case is closed staff may destroy the social and financial information of the case. The services coordinator must copy the computerized system screens and send the copies and all medical information to the MHCP Central Office.